Beth A. Gold DDS
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Marysville WA 98270
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AUTHORIZATION FORM

Authorization to Leave Voicemails/Emails

Our office may need to contact you regarding test results, appointments, referrals, or billing/insurance information. To protect your privacy and follow federal guidelines, Please select from the following:

- ☐ **DO** leave detailed messages regarding my care.
- ☐ **DO NOT** leave detailed messages regarding my care.

Phone _____ Email_____

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request treatment or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your treatment or billing records released to family members you must sign this form. Signing this form will only provide documents to family members indicated below and can be retracted at any time.

Name:_____Relation:_____

Name:_____Relation:_____

Dental Records Release

Oftentimes it is necessary to obtain your complete dental history in order to devise a treatment plan that will properly address all of your immediate and long term dental needs. This consent gives **Beth A Gold and Associates** permission to obtain your records on your (or your dependants) behalf.

Previous Dental Office:_____Phone:_____

Patient Name:_____DOB:_____

By signing, I am authorizing **Beth A Gold and Associates** to obtain and disclose my dental records in the above listed manner of my selection. I understand that this authorization form may be revoked in writing at any time.

_____DOB:_____
Print Name of Patient or Legal Guardian

_____Date:_____
Signature of Patient or Legal Guardian